KMB Consulting, LLC

91 Old Hollow Road
Trumbull, CT 06611
Phone/Fax: (203) 459-1601
Email: kbanoff@kmbconsult.com

June 21, 2006

Honorable Cristine Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: St. Vincent's Medical Center
Replacement of Simulator with CT Simulator

Dear Commissioner Vogel:

On behalf of St. Vincent's Medical Center ("St. Vincent's"), I am pleased to submit the attached Letter of Intent for the replacement of St. Vincent's existing Radiation Therapy Simulator with a CT Simulator.

The current simulator was installed in 1993 and does not offer the functionality required for current radiation therapy. CT simulation has the advantage of combining the functionality of a conventional simulator with the images, features, and display of a three-dimensional device. Contemporary radiation therapy treatment planning requires very precise target identification in three dimensions to ensure the delivery of the highest dose of radiation to the tumor site while saving healthy tissue.

Please send all applicable forms to Mr. John Ahle, Chief Financial Officer, St. Vincent's Medical Center, 2800 Main Street, Bridgeport, CT 06606.

St. Vincent's management staff and I look forward to the working with you and the Office of Health Care Access staff on this important project.

Sincerely,

Karen M. Banoff

Karen M. Banoff
Principal

Enclosures

Copy to:
John A. Ahle, St. Vincent's Medical Center

001

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	St. Vincent's Medical Center	
Doing Business As		
Name of Parent Corporation	St. Vincent's Health Services	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	2800 Main Street Bridgeport, CT 06606	
Applicant type (e.g., profit/non-profit)	Non-Profit	
Contact person, including title or position	John M. Ahle Senior Vice President/Chief Financial Officer	
Contact person's street mailing address	2800 Main Street Bridgeport, CT 06606	
Contact person's phone #, fax # and e-mail address	203-576-5551 (PH) 203-576-5345 (Fax) jahle@svhs-ct.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Replacement of Radiation Therapy Simulator with CT Simulator

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc) ☒ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than $ 1,000,000

☒ Equipment Acquisition greater than $ 400,000

☐ New ☒ Replacement ☐ Major Medical

☒ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):
2800 Main Street, Bridgeport, CT

d. List all the municipalities this project is intended to serve:

Primary market: Bridgeport, Easton, Fairfield, Monroe, Shelton & Stratford, and Trumbull
Secondary market: Milford, Newtown, Norwalk, Wilton, Weston, and Westport

e. Estimated starting date for the project: 4/1/07

f. Type of project: 13, 20 (Fill in the appropriate number(s) from page 7 of this form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
N/A				
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $977,354

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$200,000
Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	$777,354
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$977,354**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$977,354**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
CT Simulator	GE Medical Systems	LightSpeed RT	1	$777,354

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

A copy of the vendor quote is included in ***Appendix I.***

c. Type of financing or funding source (more than one can be checked):

☒	Applicant's Equity	☐	Lease Financing	☐	Conventional Loan
☐	Charitable Contributions	☐	CHEFA Financing	☐	Grant Funding
☐	Funded Depreciation	☐	Other (specify): _____		

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number:_____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant:

Project Title:

I, _____ , _____
(Name) (Position – CEO or CFO)

of _____being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that _____complies with the appropriate and (Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

ATTACHMENT I
PROJECT DESCRIPTION

St. Vincent's Medical Center ("St. Vincent's") is a 397-bed acute care hospital located in Bridgeport, Connecticut. The hospital offers a full range of medical and surgical services including centers of excellence in cardiovascular disease, cancer prevention, women's services, senior services and behavioral health services.

The Hospital is licensed by the Department of Public Health in the State of Connecticut (see Appendix II for a copy of the DPH license).

St. Vincent's Medical Center is seeking to replace its current Radiation Therapy Simulator with a CT Simulator. The current simulator was installed in 1993. Before radiation therapy treatment is started, x-ray films are taken and calculations are prepared to determine the proper angles to direct the radiation therapy rays. Historically the measurements were taken with an x-ray simulation machine. However, the current standard of care is to use a CT simulator. CT simulation has the advantage of combining the functionality of a conventional simulator with the images, features, and display of a three-dimensional device. Contemporary radiation therapy treatment planning requires very precise target identification in three dimensions to ensure the delivery of the highest dose of radiation to the tumor site while saving healthy tissue.

St. Vincent's has a large and active oncology program. The Hospital offers cancer screening, diagnosis, surgical, medical, and radiation therapy services along with a wide range of supportive care programs. The majority of oncology care is provided in the Hospital's inpatient oncology unit, the outpatient infusion suite and in the radiation oncology department

St. Vincent's has taken a leadership role in raising awareness about cancer and leading the way for significant fundraising to support patient care programs. The Hospital's Swim Across the Sound ("The Swim") event is one of the region's most exciting and compelling athletic events and has grown beyond the swim marathon to involve more than 30 events annually to raise funds to help support cancer survivors. The Swim's mission is committed to breaking down the barriers to access for cancer screening and prevention programs. It is also committed to providing education about how people can minimize their risks for cancer and improve their chances of surviving the disease. The Swim supports 34 cancer education, screening and prevention programs of which many are free.

St. Vincent's Radiation Therapy program currently performs radiation therapy treatments on close to 500 patients per year. More than 550 simulations were completed in 2005. The Hospital operates one linear accelerator and one simulator. The CT simulator will be installed in the same location as the current simulator. A CT simulator will offer better quality patient care to St. Vincent's radiation therapy patients since the simulation and the CT correlation can be completed

simultaneously in one visit. Currently patient must come to the Hospital twice for a CT correlation scan and a simulation scan.

The target population for this service is patients in the service area that require Radiation Therapy treatment. The proposed equipment will have a positive effect on the health care delivery system since it will improve the quality of care.

Other Radiation Therapy providers in the service area include:

- Bridgeport Hospital (Bridgeport); and
- Norwalk Hospital.

The service will be provided by St. Vincent's Medical Center. Payors for this service include all third party payors.

APPENDIX I

VENDOR QUOTE

GE Medical Systems
General Electric Company
P.O Box 414, Milwaukee, WI 53202-0414
gemedical.com

Quotation

Quotation For:

Rachel Giliotti
St. Vincent's Hospital
Dept. of Radiation Oncology
2800 Main Street
Bridgeport, CT 06606
(203) 576 - 6000 FAX: (203) 576 - 6370

Page: 1

Date: June 6, 2006

Quotation Number: TXR20060606-002

GENERAL ELECTRIC COMPANY is pleased to submit this quotation for the products described herein, subject to the enclosed Terms and Conditions of Sale for GEMS Products (F3730 10/02) and the following:

- **Special Terms:** Form 7985 R2/01
- **Warranty:** F3705 R10/02, Tubes 7354 R510/02, EAT 8394 R2/01 Accessories
- **Delivery Terms:**
- **Quotation Expiration Date:** July 6, 2006
- **Terms of Payment:**
- **Contract Price Protection:** 12 months from date of contract execution, subject to increase by .5% per month after such 12 month period.

GENERAL ELECTRIC COMPANY:

Submitted By:

Tommy Roberts — **Date**
Oncologic Imaging Manager
Varian Medical Systems
2250 Newmarket Parkway
Suite 120
Marietta, GA 30067
(770) 955 - 1367 FAX: (770) 955 - 6936
tommy.roberts@varian.com

Accepted By:

Date

Credit Approval By:

Date

BUYER:
Rachel Giliotti

Agreed To By:

Authorized Customer Representative — **Date**

Title

GE Medical Systems
General Electric Company
P.O Box 414, Milwaukee, WI 53202-0414
gemedical.com

Quotation

TXR20060606-002 St. Vincent's Hospital, Bridgeport, CT

Item	Qty	Product Description

Section 1

CT Simulators with Advantage Sim

1.01 1 S7888WC CT Simulator LightSpeed RT w/ Advantage Sim & LAP
GE LightSpeed RT CT Simulator with LAP

The GE Medical Systems LightSpeed RT CT Simulator with Xtream Technology is a Complete Volumetric Acquisition and Virtual Simulation System. The System Includes a LightSpeed RT Helical Whole Body CT Scanner Optimized for CT Simulation, Wide View (up to 65 cm DFOV), Oncology Workstation, Advantage Sim 6.0 Simulation Software, Advantage Fusion CT/MR Software, Laser Marking System, Exact Couch Flat Top, and a High Performance Network. The following components are included:

- o LightSpeed Operator's Console
- o LightSpeed Slip Ring Gantry
- o LightSpeed Patient Table
- o Custom Designed Image Generator
- o Matrix Detector
- o up to 6 images per Second Reconstruction
- o 6.3 MHU X-Ray Tube Unit
- o Patient Positioning and Comfort Accessories

Matrix Detector

- o A Matrix Detector Comprised of 16 Rows of Imaging Detectors, Each Row Containing 912 Cells, for a Total of 14,592 Detector Elements

LightSpeed System Gantry

- o Aperature: 80 cm
- o Tilt: +/- 30 Degrees
- o SFOV: 50 CM
- o DFOV: up to 65cm
- o Rotational Speeds: 1.0,2.0,3.0 or 4.0 seconds
- o 100cm Coverage for ScoutView
- o A 450 lb. Maximum Table Capacity.
- o Table Incrementation Accuracy of +/- 0.25mm

LightSpeed X-Ray Tube Unit

- o 6.3 MHU Heat Storage Capacity with 840 KHU/min Heat Dissipation Rate.

GE Medical Systems
General Electric Company
P.O Box 414, Milwaukee, WI 53202-0414
gemedical.com

Quotation

TXR20060606-002 St. Vincent's Hospital, Bridgeport, CT

Item	Qty	Product Description

LightSpeed X-Ray Subsystem

o 53kW High Frequency Onboard Generator.

LightSpeed Operators Console

o The LightSpeed RT Utilizes Xtream technology, with a Linux operating console and a GE-Proprietary Image Generator.

o SmartMA Utilizes A/P and Lateral Scouts to Automatically Adjust mA From Slice to Slice While Maintaining Equivalent Image Quality.

o Complete Simultaneity During Scan Acquisition

Virtually All Clinical Operations are Managed Through Three "Virtual Desktops" or Applications Managers - Exam Rx, ImageWorks and Sherlock. Operators can Effortlessly Move Back and Forth Between These Environments Simply by Clicking on an Icon. An Enhanced Multi-tasking Architecture Maintains All Processes so No Work is Lost or Disrupted as Desktops are Switched.

LightSpeed RT Scan Performance

The LightSpeed RT can Perform Virtually Any Clinical Application Due to Its Wide Variety of Scan Modes. With the LightSpeed RT, Treatment Planning scans, retrospective gating studies and conventional diagnostic Studies are Easier to Perform and more Productive than Ever Before.

Simplified Scan Prescriptions and Easy-to-Use Default Protocols Make the LightSpeed RT Fast and Easy in Patient Set Up.

The Complex Nature of Helical Multi-slice Scanning has Been Simplified by Grouping All Critical Acquisition Parameters Within Two Basic Scan Modes: HQ and HS.

For All Helical Scan Modes, the Operator can Choose to Reconstruct Images Prospectively in Any of the Defined Nominal Image Thicknesses.

GE Medical Systems
General Electric Company
P.O Box 414, Milwaukee, WI 53202-0414
gemedical.com

Quotation

TXR20060606-002 St. Vincent's Hospital, Bridgeport, CT

Item	Qty	Product Description

Restrospective Image Decomposition: The Operator has the Option to Retrospectively Decompose the Original Raw Data Set and Reconstruct Additional Images at Any of the Defined Nominal Image Thicknesses Available for a Given Table Speed and Scan Mode.

Single Acquisition Max. Scan Time: 120 sec

Multiple Acquisition Maximum Scan Time: Multiple Scans can be Acquired in One Series to Produce Up to 1500 Contiguous Helical Images. Up to 2000 Seconds Helical Coverage are Possible in Multiple Series.

Multi-slice Acquisitions and Short Interscan Delays Significantly Reduce Potential Misregistration Between Scans by Increasing the Number of Scans Possible in a Patient Breath Hold.

Axial Multi-slice Modes

The LightSpeed RT Acquires Axial Scans in Sets of Up to Four Continguous Images in One 360 Degree Rotation.

The LightSpeed RT Acquires Axial Images Up to Five Times Faster than Single-slice Scanners with the Same or Better Image Quality. Additionally, Thin-slice Acquisition Reduces Partial-volume Artifacts and Improves Image Quality Versus Conventional Single-slice Axial Scans.

For Each Rotation of the Gantry, The LightSpeed RT Collects Four Rows of Scan Data. There are Three Reconstruction Modes Available for Creating Images From the Multi-slice Scan Data (1i, 2i, and 4i). By Using 1i and 2i Reconstruction Modes, Scan Data can be Combined Prior to Image Reconstruction to Create Slices with Reduced Partial-volume Artifacts.

Peripherals

- o 181GB System Disk Stores at Least 150,000 Uncompressed 512x512 Images
- o 2000 Scan Data Files

TXR20060606-002 St. Vincent's Hospital, Bridgeport, CT

Item	Qty	Product Description

o Standard 2.3GB Magnetic Optical Disk Drive Utlizing Eraseable, Rewritable Media Provides Storage for Up to 4700 Lossless JPEG Compressed 512 Image Files Per Side and Up to 350 Uncompressed Scan Data Files Per Side
o Archiving is in a DICOM 3.0 Format Providing Improved Data Sharing and Networking
o Images may be Selected and Moved to Any Imaging System Supporting DICOM 3.0 Protocol Provides Send, Receive, and Pull/Query.

Patient Positioning and Comfort Accessories
o Axial and Supine Coronal Headholders Aid in Precise Comfortable Positioning
o Security Straps and Cradle Cushions for Additional Patient Comfort and Security
o Arm Support to Aid in IV Contrast Injection

Technical Reference Manual Includes Technical Specifications, QA, and Safety Procedures

Quality Control Phantoms

Full System Warranty Coverage (Excluding X-ray Tube) will be provided for 12 Months From Date of Installation. The Lesser of 12 Months or 100,000 Scans Pro-rated X-ray Tube Warranty Coverage Included.

Radiation Therapy Planning (RTP) Exact Couch for LightSpeed Systems. The CT Exact Couch Locks into the CT Cradle Providing a Flat Surface for Accurate and Reproducible Patient Positioning.

Oncology Workstation

The Advantage Workstation 4.2 is the platform with exceptional stability, quality and flexibility to deliver multi-modality image management, review, comparison and processing with simplicity and power. Powerful software is optimized for state-of-the art technology to provide modularity and leading edge performance. The AW 4.2 includes:
o 2D image viewer that displays RT, CT, MR, CR X-Ray (Angio and R&F), Digital X-Ray (DX),

TXR20060606-002 St. Vincent's Hospital, Bridgeport, CT

Item	Qty	Product Description

MG, NM, PET, U/S, Secondary Capture,
Secondary Capture Color DICOM Image Objects
o AW4.2 operating platform, Patient List,
database, and DICOM networking
o 2D Viewer
o Filmer
o Data Export
o Advanced X-ray Analysis
o One 18" flat panel monitors
o HP Xw8000 Workstation:
- Dual Intel Xeon Processor 2 x 3.06GHz CPU clock speed, 512KB cache per CPU
- 2GB RAM
- 2 x 73 GB: Ultra320 SCSI 15,000rpm hard disks (120 GB can be used for image storage)
- Internal CD-ROM burner (40x read/write) for DICOM media interchange and writing of DataExport electronic films
- 10/100/1000 base-T network interface
- US PS2 and mechanical 3-button mouse
- 3 inch floppy drive for service use and preset archive capability

Advantage Sim 6.0

Advantage Sim 6.0 is Used to Prepare Geometric and Anatomical Data Relating to a Proposed External Beam Radiotherapy Treatment Prior to Dosimetry Planning. Anatomical Volumes can be Defined in Three Dimensions Using a Set of CT Images Acquired with the Patient in the Proposed Treatment Position. The Geometric Parameters of a Proposed Treatment Field are Selected to Allow Non-dosimetric, Interactive Optimization of Field Coverage. Anatomical Structures and Geometric Treatment Fields are Displayed on Transverse CT Images, or Reformatted Sagittal, Coronal or Oblique Views Structures are displayed with or Without the Digitally Reconstructed Radiograph.

Speed:

The Package Allows Complete 3D Volumes to be Defined and Manipulated Using Automatic Thresholding Tools, Structure Drawing with or Without "Live Wire" to Pixel Value

Item	Qty	Product Description

Gradients and Automatic Interpolation. Beam Placement is facilitated with Automatic Isocenter Placement and Beam's Eye View.

Ease of Use:

The Package is Mouse Driven with a Windows User Interface. The Press of a Single Button Using Pre-defined and Configurable Treatment Plan Templates Linked to Patient Anatomy Offers Many Functions. Protocol Specific Structure Names and Properties, Beam Geometry and Field Shape can be Loaded From a Palette of Templates. Pre-defined Sequences of Actions can Then be Applied Adding to the Ease of Use.

Flexibility:

Contouring and Field Definition Parameters can be Modified on the Fly to Allow Thresholds, Margins and Display Characteristics to be Tailored to a Given Patient Data Set.

Efficiency:

The Package is Designed for Use Independently of a Treatment Planning System, Enabling the Physician to Define Volumes and Select Treatment Technique at a Dedicated Workstation. Any Plan can be Saved and Pushed to a RTP System as Standard DICOM RT Objects. DICOM RT Structure Set and RT Plan Objects can also be Received From DICOM RT Compliant Systems

Advantage Fusion CT/MR

Advantage Fusion is a Software Application Which Provides Easy Comparison of Three Dimensional (3D) Images From CT and MR. It Allows 3D Registration Between Two Volumetric Acquisitions

The Registration is Based on the Automatic Identification of Common Surfaces and User Validated by Localization of Common Landmarks. Visual Feedbacks and Scores are Provided to Assess Matching Accuracy.

TXR20060606-002 St. Vincent's Hospital, Bridgeport, CT

Item	Qty	Product Description

Advantage Fusion Displays Real Time Axial, Sagittal and Coronal MPR Views for Both Exams. Multiple Correlated or Fused Display Options Bring Out the Full Information From Both Acquisitions.

Advantage Fusion Results may either be a fused or Registered Stack of DICOM Images, and Registered Graphic Contours Defined From One Modality and Reported Into the Other Modality. Those Contours can be Saved Using the ACR NEMA DICOM RT Structure Set Standard Object.

CT LAP Laser Isocenter Marking System Consists of Three Moveable Solid State Red Crosshair Lasers on a Computerized Rail for Marking Patients. Includes Rail System, Computerized Keypad/Display Terminal; Isomark Software; Computer System and Installation. Room Preparation Must be Sufficient for the Mounting of the Lasers

Performance Network Kit Contains a 10/100 Mbit Ethernet Switch, Transceivers, and UTP Cable for Up to Six Networked Devices installation included.

CT Applications Training

1.02 1 W0100CT Six Days CT On-Site Training

CT On-Site System Training for HiSpeed and Lightspeed Systems.
One (1) Four (4) Day On-Site Visit to coincide with system start-up.
One (1) Two (2) Day On-Site Follow-Up Visit (6-8 Weeks post system start-up).

1.03 1 B7500CT CT Advantage Sim On-Site Training - 2 1/2 Days

CT Advantage Sim On-Site Training. Two and a half days (2 1/2) at start up.

Respiratory Gating

1.04 1 S7840DC Advantage 4D for LightSpeed RT and PRO 16 Style

Advantage 4D is a non-invasive software/hardware option that can be used to provide and display CT images of all phases of a breathing cycle for the evaluation of respiration-induced motion.
The software will allow the user to retrospectively define the best respiratory phase from an image quality standpoint and group images by the phase selected.
Advantage 4D can also be used for target or treatment volume (DICOM Radiation Therapy Structure Sets) verification.

GE Medical Systems
General Electric Company
P.O Box 414, Milwaukee, WI 53202-0414
gemedical.com

Quotation

TXR20060606-002 St. Vincent's Hospital, Bridgeport, CT

Item	Qty	Product Description	
		*Does not include Varian's Respiratory Gating Option.	
		Filming Options & Injectors	
1.05	1	**E8007NA Medrad Stellant SX Injector w/Pedestal Mount**	
		CT Applications Training	
1.06	1	**B7500CS Advantage 4D On-Site Training - 1 1/2 Days** Advantage 4D On-Site Training - 1 1/2 days.	
		Workstation and Other Options	
1.07	1	**B79021MF Advantage SimMD Upgrade w/AS & MMMP** The Workstation must be at a 4.2P level for Advantage SimMD.	
		Section Total $	**777,354.00**

Section 2

Section Total $	**0.00**

Terms & Conditions of Sale

This offer is subject to credit approval and is exclusive of any applicable sales taxes or duties.

All progress payments, including the delivery portion, are due to GE Medical Systems prior to final system calibration. GE Medical Systems reserves the right to delay final system calibration until all such payments are received.

If we incur any collection expenses for past due payments, we reserve the right to charge you for such expenses, up to the amount of 10% of the past due payments, and you agree to reimburse us for such expenses.

We will accept order changes up to 5 weeks prior to the scheduled arrival date (the expected equipment delivery date) or within 3 business days after we receive your order. We reserve the right to deny late change requests. If we accept late requests, delivery may be delayed.

ANY CONTRACT RESULTING FROM THIS QUOTATION WILL BE BASED SOLELY AND EXCLUSIVELY ON GENERAL ELECTRIC COMPANY'S STANDARD CONDITIONS OF QUOTATION AND OTHER TERMS AND CONDITIONS CONTAINED IN OR REFERENCED BY THIS QUOTATION.

ITEMS ASSOCIATED WITH THE ORDERED PRODUCTS AND PROVIDED UNDER THIS QUOTATION WITHOUT SEPARATELY IDENTIFIED CHARGE CONSTITUTE "DISCOUNTS OR OTHER REDUCTIONS IN PRICE" UNDER APPLICABLE FEDERAL LAW (42 U.S.C. 1320a-7b).
IT IS THE CUSTOMER'S RESPONSIBILITY TO DISCLOSE SUCH "DISCOUNTS OR OTHER REDUCTIONS IN PRICE" AS MAY BE REQUIRED UNDER ANY STATE OR FEDERAL PROGRAM WHICH PROVIDES COST OR CHARGE BASED REIMBURSEMENT TO THE CUSTOMER FOR THE PRODUCTS OR SERVICES PROVIDED UNDER THIS QUOTATION.

FOR "NL" OR "NW" PREFIXED CATALOG NUMBERED PRODUCTS, OTHER THAT "NL521", "NL528", "NL531", OR "NL538", GE DOES NOT PROVIDE PRE-INSTALLATION OR EQUIPMENT PLANNING SERVICES, INSTALLATION, WARRANTY, SERVICE PARTS OR APPLICATION SUPPORT.

"FOR 'E' PREFIXED CATALOG NUMBERED PRDUCTS, THE SINGLE LETTER (A THROUGH H) SHOWN AT THE ENDS OF THE QUOTATION DESCRIPTION INDICATES THE SERVICE CODE FOR THE PRODUCT. AN EXPLANATION OF THIS CODE IS FOUND ON THE REVERSE SIDE OF THE ACCESSORIES WARRANTY INCLUDED WITH THIS QUOTATION."

PRICES SHOWN IN THIS QUOTATION DO NOT INCLUDE TAXES. WHERE APPLICABLE, THEY WILL BE ADDED AND SHOWN SEPARATELY ON INVOICES AT TIME OF BILLING.

IF YOU ARE TAX EXEMPT AND THIS IS YOUR FIRST ORDER WITH GE MEDICAL SYSTEMS, PLEASE REMIT A COPY OF YOUR TAX EXEMPTION CERTFICATE WITH YOUR ORDER.

IF THIS ORDER INCLUDES PRODUCTS MANUFACTURED BY GE MEDICAL SYSTEMS INFORMATION TECHNOLOGIES, INC. ("GEMS-IT"), A SUBSIDIARY OF GENERAL ELECTRIC COMPANY, (A) GEMS-IT WILL INVOICE YOU SEPARATELY FOR THE PORTION OF THE QUOTATION PURCHASE PRICE ATTRIBUTABLE TO SUCH GEMS-IT PRODUCTS, PER THE SAME PAYMENT TERMS REFERENCED HEREIN, AND YOU AGREE TO PAY GEMS-IT FOR SUCH PORTION OF THE PURCHASE PRICE, AND (B) UNLESS A SEPARATE GEMS-IT WARRANTY IS REFERENCED IN AND ATTACHED TO THIS QUOTATION, SUCH GEMS-IT PRODUCTS WILL BE COVERED BY A 12 MONTH WARRANTY PER THE TERMS OF THE GEMS CONSOLIDATED PRODUCT WARRANTY.

APPENDIX II

DPH LICENSE

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0057

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

St. Vincent's Medical Center of Bridgeport, CT, d/b/a St. Vincent's Medical Center is hereby licensed to maintain and operate a General Hospital.

St. Vincent's Medical Center is located at 2800 Main Street, Bridgeport, CT 06606

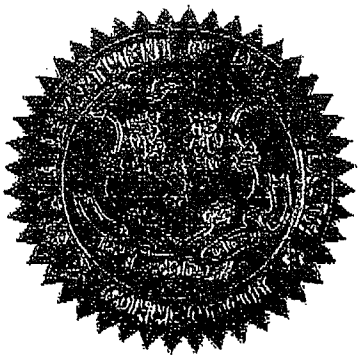
The maximum number of beds shall not exceed at any time:
47 Bassinets
397 General Hospital beds

This license expires **September 30, 2007** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2005. RENEWAL.

Satellites

St. Vincent's Immediate Health Care, 4600 Main Street, Bridgeport, CT
St. Vincent's Immediate Health Care, 1055 Post Road, Fairfield, CT
St. Vincent's Immediate Health Care, 15 Armstrong Road, Shelton, CT
St. Vincent's Medical Center, Neighborhood At St. Joseph's Center, 43 Madison Avenue, Bridgeport, CT
Family Health Center, 760-762 Lindley Street, Bridgeport, CT
St. Vincent's Immediate Health Care, 401 Monroe Turnpike, Monroe, CT



J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 27, 2006

John Ahle
Senior Vice President
Saint Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

Re: Letter of Intent, Docket Number 06-30774
Saint Vincent's Medical Center
Acquisition of a CT Simulator in Radiation Therapy Unit through Replacement of X-ray Simulator
Notice of Letter of Intent

Dear Mr. Ahle:

On June 23, 2006, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Saint Vincent's Medical Center ("Applicant") for the acquisition of a CT simulator in radiation therapy unit through replacement of x-ray simulator, at a total capital expenditure of $977,354.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Connecticut Post* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:LG:dpd

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 27, 2006

Requisition # HCA07-013
FAX #: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Saturday, July 1, 2006.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Laurie Greci at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:dpd

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Saint Vincent's Medical Center
Town:	Bridgeport
Docket Number:	06-30774-LOI
Proposal:	Acquisition of a CT Simulator in Radiation Therapy Unit through Replacement of X-ray Simulator
Total Capital Expenditure:	$977,354

The Applicant may file its Certificate of Need application between August 22, 2006 and October 21, 2006. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0866
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	06/27 12:05
TIME USE	00'19
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
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Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 28, 2006

John Ahle
Senior Vice President
Saint Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606-0492

RE: Certificate of Need Application Forms, Docket Number 06-30774-CON
Saint Vincent's Medical Center
Replace X-ray Simulator with CT Simulator in Radiation Therapy Unit

Dear Mr. Ahle:

Enclosed are the application forms for Saint Vincent's Medical Center's Certificate of Need ("CON") proposal for the Replace X-ray Simulator with CT Simulator in Radiation Therapy Unit with an associated capital expenditure of $977,354. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 22, 2006, and October 21, 2006.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. Please feel free to contact him/her at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than August 22, 2006, and may be submitted no later than October 21, 2006. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 06-30774-CON

Applicant's Name: Saint Vincent's Medical Center

Contact Person: John Ahle
Contact Title: Senior Vice President
Contact Address: Saint Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606-0492

Project Location: Bridgeport

Project Name: Acquisition of a CT Simulator in the Radiation Therapy Unit through Replacement of X-ray Simulator

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $977,354

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
a) Primary and secondary service area towns
b) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
c) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
d) Scheduling backlogs in service area
e) Travel distance from proposed site to service area towns
f) Hours of operation of existing/proposed service

ii) Identify the existing providers of the proposed service in your service area.

iii) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iv) Provide the units of service projected for the first three years of operation of the proposed service. Include the derivation/calculation.

v) Provide the information as outlined in the following table concerning the existing providers' (in the Applicant(s) PSA & SSA) current operations:

Description of Service[1]	Provider Name and Location	Hours and Days of Operation[2]	Current Utilization[3]

[1] If proposal concerns imaging equipment, provide a description of the equipment used by the Provider, if known.
[2] Specify days of the week and start and end time for each day.
[3] Number of scans performed on specified scanner by Provider for the most recent 12 month period, if known.

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____

_____

_____

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter- of Radiology	☐ American College Abuse and Mental Health Services	☐ Substance Society Council for Radiation Oncology Administration

☐Other: Specify _____

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH	☐ JCAHO
☐ Fire Marshall Report	☐ Other States Health Dept. Reports (new out-of-state providers)
☐ AAAHC	☐ AAAASF
☐ Other: _____	

Note: Above referenced acronyms are defined below. [1]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

F. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital (Applicant), Physicians and any staff related to the proposal, for the past five (5) years.

G. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital (Applicant), Physician(s) working at the Hospital and/or any staff related to the proposal.

H. Provide a copy of the following (as applicable):

☐ A copy of the related Quality Assurance plan

☐ Protocols for service (new service only)

☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

iv) Provide the name and units of service for the new cost center to be established for the proposal.

v) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	_____
CON Proposed debt financing	_____
Interest rate	_____%
Monthly payment	_____
Term	_____ Years
Debt service reserve fund	_____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	
CON Proposed lease financing	
Fair market value of leased assets at lease inception	
Interest rate	%
Monthly payment	
Term	Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
i. Letter of interest from the lending institution,
ii. Letter of interest from CHEFA,
iii. Amortization schedule (if not level amortization payments),
iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Provide a copy of the rate schedule for the proposed service.

v) Describe how this proposal is cost effective.

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

11. C (i). Please provide one year of actual results and three years of Saint Vincent's Medical Center's projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System: **Description**	**FY Actual Results**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.